

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Inf. from birth certificate

Reg. D. No. 12542

1. PLACE OF DEATH a. COUNTY <i>Clay</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clay</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Ghost Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby boy Butler</i>		First <i>Bob</i>	Middle <i>Lee</i>
		Last <i>Butler</i>	Twin
4. DATE OF DEATH Month <i>Nov</i>		Day <i>16</i>	Year <i>1961</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11-16-61</i>		9. AGE (in years less birthday) yr. <i>1</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>Maryland</i>		13. FATHER'S NAME <i>James Roger Thomas</i>	
14. MOTHER'S-MAIDEN NAME <i>Dolores Yvonne Butler</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>776X</i>		17. INFORMANT <i>Delivery</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Delivery at home</i>		INTERVAL BETWEEN ONSET AND DEATH <i>gestation 24 weeks</i>	
DUE TO <i>Delivery at home</i>			
DUE TO <i>Delivery at home</i>			
DUE TO <i>Delivery at home</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Delivery at home</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Delivery at home</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Delivery at home</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Delivery at home</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>Delivery at home</i>			
ACTUAL SIGNATURE <i>S. E. Edelen</i>		DATE SIGNED <i>11-16-61</i>	
EXAMINER'S NAME (Type) <i>S. E. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Delivery at home</i>		22b. DATE THEREOF <i>11-18-61</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burkhardt & Son</i>		ADDRESS <i>100172 XV</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Evans</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	
DATE NOV 21 '61			

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12554

Int. from birth certificate

Reg. Dist. No. 12543

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Oxon Hill, Maryland		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 1 week	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS X Neenbrygh	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Last Twin II	
First Middle		Month Day Year 11 16 61	
5. SEX F		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. Months Days Hours Min.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-16-61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? Address	
Maryland		Dolores Yvonne Butler	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Dolores Roger		Dolores Yvonne Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Natural death	
776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO gestation	
(b)		DUE TO Delivery at home	
(c)		Midwife	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 11-16-61	
ACTUAL SIGNATURE Dolores		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Ed. Eber			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-61	
22c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost		22d. LOCATION (City, town, or county) Towson	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Lee Lopola Inc.		24a. REC'D BY REGISTRAR NOV 21 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12544

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rewick		c. LENGTH OF STAY IN 1b 10-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rewick		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Althea May Day		First	Middle	Last	4. DATE OF DEATH 11-25-61	Month	Day	Year 19	
5. SEX Female	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1916	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Rodger Thompson		14. MOTHER'S MAIDEN NAME Zoe Floyd		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth Webb-(Sister)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Myocarditis Acute DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emotional Instability			INTERVAL BETWEEN ONSET AND DEATH 21-Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Indian Head	(County)	(State)			
21. I certify that I attended the deceased from 11-4-61 , 19, to 11-25-61 , 19, that I last saw the deceased alive on 11-24-61 , 19, and that death occurred at 6:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James E. Andrews</i>		ADDRESS (Street, city or town, state) Indian Head, Md.					DATE SIGNED 11-25-61		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-27-61	22c. NAME OF CEMETERY OR CREMATORIAL BUMPY OAK	22d. LOCATION (City, town, or county) POMONKEY, MD.			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE HUNTT Funeral Home, WALDORF, MD.		ADDRESS	24a. REC'D BY REGISTRAR NOV 28 '61	24b. REGISTRAR'S SIGNATURE James S. Thomas			DATE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12556

12545

M

PLACE OF DEATH
a. COUNTY

Charles

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Md

b. COUNTY

Charles

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Bel Alton

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

66
I
3. NAME OF
DECEASED
(Type or print)

First
Middle
Last

4. DATE
OF
DEATH
Month
Day
Year

5. SEX

Male

6. COLOR OR RACE

Col

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

Sept 12 1861

9. AGE (In years
last birthday)
yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MARRIED NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

772.0

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause (b)

DUE TO

(c)

malsnutrition

INTERVAL BETWEEN
ONSET AND DEATH

2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
at work at work

20e. PLACE OF INJURY (Name, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-19 1961 to 11-21 1961, that (I) (we) last
saw the deceased alive on 11-20 1961, and that death occurred at 54 M. from the causes and on the date stated above.

22a. SIGNATURE

J. M. Johnson

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
11-20-61

22c. PHYSICIAN'S
NAME (Type)

F. M. JOHNSON M.D.

22d. ADDRESS

La Plata, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Death Funeral Home, Inc. — La Plata, Md.

DATE NOV 27 '61

Arthur S. Krause

64654

HTAG TO HABERBER

64654

12557

12546

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORMAN RUSSELL FORD		First	Middle
4. DATE OF DEATH Nov 21 1961		Last	Month
5. SEX MALE		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JAN. 19, 1960		9. AGE (In years lost birthday) 22 yrs.	10. IF UNDER 1 YEAR 22 Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	10c. BIRTHPLACE (State or foreign country) MARYLAND
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MOTHER'S MAIDEN NAME Elsie Cecelia Miles	
13. FATHER'S NAME Thomas William FORD SR.		14. Address Thomas W. FORD, Mt Victoria, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Thomas W. FORD, Mt Victoria, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malabsorption syndrome DUE TO 289.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congenital defect in metabolism DUE TO 22 months (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1960 20f. (City or town) La Plata (County) Md. (State) Md.
21. I certify that (I) (this hospital) attended the deceased from Now 1961 to 11-21 1961, that (I) (we) last saw the deceased alive on 11-20 1961, and that death occurred at La Plata, Md. from the causes and on the date stated above.			
22a. SIGNATURE F.M. Johnson		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-21-61
22c. PHYSICIAN'S NAME (Type) F.M. Johnson MD		22d. ADDRESS La Plata, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-22-61	23c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost Cem.
23d. LOCATION (City, town, or county) (State) Issue, Maryland		23e. REC'D BY REGISTRAR DATE NOV 24 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, WALDORF MD		25e. REGISTRAR'S SIGNATURE Arthur S. Trahan	

12547
FOR STATE
HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12547

1. PLACE OF DEATH a. COUNTY		CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		N.Y.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY					
LAPLATA									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		D.O.H. Physicians Memorial Hospital		d. STREET ADDRESS		ALBANY 69X-3			
3. NAME OF DECEASED (Type or print)		First JOHN	Middle	Last	4. DATE OF DEATH	Month 11	Day 7		
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-93	9. AGE (In years last birthday) 168 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (?)		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE Co.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isack Fuller		14. MOTHER'S MAIDEN NAME Lenora Landers		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes W.W. I		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Mrs. Rose Fuller-23 Vly Road, Albany 5, N.Y.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Previous C. O. C. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 11-7-61	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE E. J. EDELEN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-7-61	
EXAMINER'S NAME (Type)		EXAMINER'S ADDRESS La Plata, Charles, Md.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		(State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		22b. DATE THEREOF 11/7/1961		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Memorial Evergreen Cemetery & Schenectady, New York		22d. LOCATION (City, town, or country)		(State)	
23. FUNERAL DIRECTOR Richard Funeral Home, Inc.		ADDRESS La Plata, Md.		24a. REC'D BY REGISTRAR NOV 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	
VS. A15ME 5M 9/60									

SECRET



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

1 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 13 BRYANTOWN (RURAL)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS' MEMORIAL HOSP.			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First ALICE Middle MARY Last JAMESON			4. DATE OF DEATH Month NOVEMBER Day 10 Year 1961		
5. SEX FEMALE		6. COLOR OR RACE W-WS		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH MAY 7, 1878	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME JOHN F. MUDD			14. MOTHER'S MAIDEN NAME EMOGENE MILES		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO			16. SOCIAL SECURITY NO. 217-36-727		
17. INFORMANT JOHN F. JAMESON: BRYANTOWN, MD.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY SCLEROSIS (CARDIAC FAILURE) INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS.			INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Generalized ARTERIO-SCLEROSIS 10 years.			(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JULY 19 1961 to NOVEMBER 10 1961, that (I) () last saw the deceased alive on NOVEMBER 10 1961, and that death occurred at 500 AM from the causes and on the date stated above.					
22a. SIGNATURE John H. Griffin			22b. DATE SIGNED 11-12-61		
22c. PHYSICIAN'S NAME (Type) JOHN H. GRIFFIN			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS HUGHESVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/13/61		23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S	
23d. LOCATION (City, town, or county) BRYANTOWN, MD.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE HUNTER FUNERAL HOME			ADDRESS WALTERS, MD		
25a. REC'D BY REGISTRAR DATE NOV 16 1961			25b. REGISTRAR'S SIGNATURE Charles L. Thorne		

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FOR STATE
HEALTH DEPT.

TO DEFENDANT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12549

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residencia before admission) a. STATE	
Charles County MARYLAND		Maryland Charles	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Nanjemoy		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Nanjemoy (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Edelen Medical Building		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) AVERY		First MIDDLE CORTEZ	4. DATE OF DEATH November 21, 1961
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH September 27, 1961		9. AGE (in years last birthday) 1 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Freedmen's Hospital - Maryland		12. CITIZEN OF WHAT COUNTRY Washington, D.C. U.S.A.	
13. FATHER'S NAME Theodore Keys		14. MOTHER'S MAIDEN NAME Evelyn Keys	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT		Address Mr. Theodore R. Keys - Nanjemoy, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
525X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED Whila Not Whila at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Howard G. Shaub	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HOWARD G. SHAUB.		DATE SIGNED 11/21/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/1961	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Cemetery		22d. LOCATION (City, town, or country) Nanjemoy, Charles Co., Md.	
23. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, MD		24a. REC'D BY REGISTRAR NOV 27 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHAS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Mem.		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EUGENE K.	Middle Lloyd	4. DATE OF DEATH Last 11 Month 11 Day 6 Year 1961
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Seafood Ret. Seafood Packing Chas Co and		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Glennon T Lloyd		11. BIRTHPLACE (State or foreign country) Chas Co and USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. 217-32-0957		17. INFORMANT Eugene K Lloyd Jr Baltimore Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CONGESTIVE HEART FAILURE 11-2-61	
593 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) HYPER TENSION 1958	
		DUE TO (c) NEPHRITIS 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) 1906 (County) 11-2-61 (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on 11-1-61 and that death occurred at 9:15 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE E. J. EDELEN M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS LA PLATA MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-61	
23c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost		23d. LOCATION (City, town, or county) Issue (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Report Inc La Plata Md		25a. REC'D BY REGISTRAR DATE NOV 10 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
12551
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please initial the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - HUGHESVILLE		b. COUNTY CHARLES	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - HUGHESVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ROBERT		First ODE	Middle MARTIN
4. DATE OF DEATH NOV. 6, 1961	Month NOV.	Day 6	Year 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 30, 1879
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) 82 yrs.
		DIVORCED <input type="checkbox"/>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAWYER
			10b. KIND OF BUSINESS OR INDUSTRY SAW Mill
			11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY HARRISON MARTIN	14. MOTHER'S MAIDEN NAME UNK	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service) NO	
		16. SOCIAL SECURITY NO. 217-07-7027	17. INFORMANT HOWARD H. MARTIN, HUGHESVILLE, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 15 min	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Acute Coronary Thrombosis	
DUE TO (c)		Generalized Arterio-Sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE John H. Griffin M.D. EXAMINER'S NAME (Type) JOHN H. GRIFFIN ACTING DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) WALDORF, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-8-61	22c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial Gardens	22d. LOCATION (City, town, or country) (State) WALDORF, MD.
23. FUNERAL DIRECTOR The Hunt Funeral Home, WALDORF, MD.	ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 9 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Hunt

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the job card prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 & 22a film G302 12/4/61 iwk

Reg. No. 12552

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grayton		c. LENGTH OF STAY IN 1b 58-Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1000 Worcester Street	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura C. Montgomery		First	Middle
4. DATE OF DEATH 11-22-61		Last	Month Day Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8-8-1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Peter Cunningham		14. MOTHER'S MAIDEN NAME Sarah Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Thomas Montgomery—(Husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Hypertension DUE TO (c) Cerebral Sclerosis			
INTERVAL BETWEEN ONSET AND DEATH 6 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Patent Cess Heart Disease Melitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James E. Andrews</i>		DATE SIGNED 11-22-61	
EXAMINER'S NAME (Type) JAMES E. ANDREWS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 11/26/61	
22c. NAME OF CEMETERY OR CREMATORIAL Oak Grove		22d. LOCATION (City, town, or county) Glendale Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson & Jenkins 4804 Glendale</i>		ADDRESS 4804 Glendale	
24a. REC'D BY REGISTRAR NOV 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

DEPARTMENT OF HOMELAND SECURITY - STATE OF MARYLAND

DEPARTMENT OF HOMELAND SECURITY - STATE OF MARYLAND

DEPARTMENT OF HOMELAND SECURITY - STATE OF MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12564 12554

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Mem. Hospital		d. STREET ADDRESS "Oakwood"	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nannie	Middle Bowling	Last ROSES
4. DATE OF DEATH	Month Nov	Day 5	Year 1961
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1879
9. AGE (In years last birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) Aquasco, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME E. Gill Bowling		14. MOTHER'S MAIDEN NAME Nannie Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Romeo Freer - La Plata, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
153.1 DUE TO <i>Cardiac Failure</i> 2 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b)			
DUE TO <i>Intestinal resection (colon)</i> 6 days.			
(c) <i>Carcinoma of hepatic flexure</i> 8 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>after Nov 5, 1961</i> to <i>Nov 5, 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 5, 1961</i> , and that death occurred at <i>La Plata, Md.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>F.M. Johnson MD</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>Nov 5, 1961</i>
22c. PHYSICIAN'S NAME (Type) F.M. Johnson MD		22d. ADDRESS <i>La Plata, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/3/1961	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Rest Cemetery	23d. LOCATION (City, town, or county) (State) La Plata, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Funeral Home, Inc.</i>		ADDRESS <i>Archard Funeral Home, Inc. - La Plata, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>Nov 10, 1961</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>

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FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12555

Item 14 Film G301 11/27/61 wk

1. PLACE OF DEATH a. COUNTY Charles County LaPlata MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charles County		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft. Lauderdale	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physician's Memorial Hospital		d. STREET ADDRESS 5741 Bonita Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence C. Salvo		4. DATE OF DEATH November 16, 1961	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-13-65		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Joseph Salvo		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <input type="checkbox"/> If yes give war or dates of service		16. SOCIAL SECURITY NO. 17. INFORMANT 105-32-2089 Bettina Salvo Fort Lauderdale Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest 8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (d) DUE TO (e)		Address INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Driver of auto in two car collision	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 4:30 p.m. Nov. 14, 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301		2f. (City or town) (County) (State) LaPlata, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Howard G. Shaub	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) HOWARD G. SHAUB, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/18/61	
22c. NAME OF CEMETERY OR CREMATORIAL Lee's		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR Leibert Inc LaPlata Md.		24a. REC'D BY REGISTRAR NOV 21 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Albert S. Kraus	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Date No. 12556

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE NEW YORK b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN lb 1 day.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Howard Johnsons Motel.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARKLEY HTS	
3. NAME OF DECEASED (Type or print) KENNETH ROLAND SNYDER		4. DATE OF DEATH Month Nov Day 11 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Aug 1902
9. AGE (In years (last birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker	11. KIND OF BUSINESS OR INDUSTRY Hardware Store	12. BIRTHPLACE (State or foreign country) Saugerties N.Y. U.S.A.
13. FATHER'S NAME Henry M SNYDER	14. MOTHER'S MARRIED NAME Cenetta Weidler	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> [If yes, give war or dates of service] No	
16. SOCIAL SECURITY NO. 074-03-787		17. INFORMANT Wife: Leona May Snyder -	Address Barkley Hts. N.Y.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Acute myocardial infarction</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> ONSET AND DEATH DUE TO <u>2 hrs.</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. — p. m. —	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11 th Nov 1961
22a. BURIAL, CREMATION REMOVAL (Specify)	22b. DATE THEREOF 11/11/61	22c. NAME OF CEMETERY OR CREMATORIAL Blue Mt.	22d. LOCATION (City, town, or county) Saugerties N.Y. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Reharts Inc. La Plata Md.	ADDRESS	24a. REC'D BY REGISTRAR NOV 21 '61	24b. REGISTRAR'S SIGNATURE Clinton & Hause

14
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12557

Any delay is necessary,
excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>NEW YORK</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Maryland</i>		b. COUNTY <i>✓</i>	
c. LENGTH OF STAY IN lb <i>Transient</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>NEW YORK</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i></i>		d. STREET ADDRESS <i>629 EAST 6TH STREET</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		69X-3	
3. NAME OF DECEASED (Type or print) <i>Morris</i>		4. DATE OF DEATH Last <i>SZLAK</i> Month <i>11</i> Day <i>2</i> Year <i>1961</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATCHMAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>JEWELRY</i>	
10c. FATHER'S NAME <i>DAVID SZLAK</i>		11. BIRTHPLACE (State or foreign country) <i>POLAND</i>	
15. WAS EVER IN U.S. ARMED FORCES? (Yes, no, or other) <i>NO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>NONE DAVID SZLAK, New York, N.Y.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture base of skull</i>		<i>11-2-61</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Multiple Head Injuries.</i>			
DUE TO (b) <i>Auto Accident</i>			
DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Auto left Hiway - thrown out</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year <i>11-2-61</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Vacant lot</i>		20f. (City or town) <i>14</i> (County) <i></i> (State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		Address (Street, city, town, or county) <i>New York, New York</i>	
22b. DATE THEREOF <i>11-3-61</i>		(State) <i></i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i></i>		22d. LOCATION (City, town, or country) <i>New York, New York</i>	
23. FUNERAL DIRECTOR <i>Hunt Funeral Home, WOODSTOCK, MD</i>		(State) <i></i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 8 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Albert S. Thomas</i>	

SEARCHED 10731
INDEXED 10731
SERIALIZED 10731
FILED 10731

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12568

CERTIFICATE OF DEATH

Reg. Dist. No. 12558

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Marbury Md</i>		b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>		c. LENGTH OF STAY IN lb <i>60-Yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Harry</i>	Middle <i>Irving</i>	Lost	4. DATE OF DEATH <i>11-26-61</i>	Month <i>11</i>	Day <i>26</i>	Year <i>1961</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W-US</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-8-1883</i>	9. AGE (In years lost birthday) <i>78</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Govt. Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Manufacturing</i>		11. BIRTHPLACE (State or foreign country) <i>Crossroads Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William Alexander Warder</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-28-9528</i>		17. INFORMANT <i>Mary Warder-(Daughter in Law)</i>		Address <i>#18 Cypress Pl. Indian Head, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anemia</i>		153.2				INTERVAL BETWEEN ONSET AND DEATH <i>one Year</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <i>Carcinoma Descending Colon</i>				Indefinite			
DUE TO		DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		General asthenia caused by anemia and malnutrition, unable to take food				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>General asthenia caused by anemia and malnutrition, unable to take food</i>							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>17 Potomac Ave.</i>		(County) <i>Indian Head</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>5-10-61</i> , 19_____, to <i>11-26-61</i> , 19_____, that I last saw the deceased alive on <i>11-26-61</i> , 19_____, and that death occurred at <i>3:30PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James E. Andrews</i>						ADDRESS (Street, city or town, state) <i>17 Potomac Ave. Indian Head Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/28/1961</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Park Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Marbury</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arehart Funeral Home, Inc. La Plata, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>NOV 29 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1-
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12569

12559

1. PLACE OF DEATH
a. COUNTY

CHARLES

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

NEWBURG

c. LENGTH OF STAY IN 1b

LIFE

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

Randolph

Middle

Last

WHALEN

4. DATE
OF
DEATH

Month
11

Day
3

Year
1961

5. SEX

6. COLOR OR RACE

MALE

NEGRA

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Feb 7 1897

9. AGE (In years
last birthday) 64

IF UNDER 1 YEAR

Months
Yrs.

IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

FARMING

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SANFORD WHALEN

14. MOTHER'S MAIDEN NAME

BETTY WARREN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)

YES WWI

16. SOCIAL SECURITY NO.

213-40-8925

17. INFORMANT

GEORGE WHALEN, FAULKNER MD.

Address

18. CAUSE OF DEATH (Enter only one cause of death for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

CORONARY Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
11-3-61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

E. J. Edelen

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

E. J. Edelen

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

11-4-61

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22f. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

NOV 9 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

The Hunt Funeral Home, Waldorf, MD.

212

43 2221 ? 837

513-4C-848

AM 1960/1 10-8-11
(1A, 1960/1, month 10, year 1960)